

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 9-17-01.
- b. The request was received on 1-28-02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. TWCC 66a
 - c. EOB
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of their copy of the request on. The Respondent did not submit a response to the request. The "No Response Submitted" sheet is reflected in Exhibit II of the Commission's case file.
3. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 5-9-02:

"We have submitted a claim to the Carrier for date of service 09-17-01 for the medication Flexeril 10mg #100 in the amount of \$135.94. Total dollar amount in dispute is \$5.24...In accordance with the Pharmaceutical Fee Guideline Section II states for computing fair and reasonable fees, the following formula shall be utilized for brand name medications: AWP x number of units x 1.09 x \$4.00 – MAR. In this case the patient received 100 pills the AWP is 120.13 (for 100 pills) x 1.09 – 130.94 + \$4.00 - \$134.94. Therefore, reimbursement should be \$134.94 not the \$129.70 the Carrier paid."
2. Respondent: No Response was noted in the dispute packet from the Respondent.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 9-17-01.
2. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
9-17-01	Flexeril 10 mg #100	\$135.94	\$129.70	F	No MAR	MFG; Pharmaceutical Fee Guideline; (I) (A); (II) (A);	<p>The Carrier has denied the charge in dispute as "F – F – REIMBURSED ACCORDING TO THE TEXAS FEE GUIDELINES".</p> <p>Billing is in compliance with the Pharmaceutical Fee Guideline. Therefore, additional reimbursement is recommended in the amount of \$5.34.</p>
Totals		\$135.94	\$129.70				The Requestor is entitled to reimbursement in the amount of \$5.34 .

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$5.34 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 6th day of September 2002.

Lesia Lenart, RN
 Medical Dispute Resolution Officer
 Medical Review Division

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